DIVISION OF MEDICAID

Inquiry or Complaint Form

www.medicaid.ms.gov/mscan

Date	
Provider Name	
Provider Number	
Contact Person	
Telephone Number	
Cell Phone Number	
Beneficiary Name	
Beneficiary Number	
Telephone Number	
Have you spoken to anyone at Medicaid?	□ No □ Yes. If so, please state name below. Name_____

What is this regarding?

(Please check.)

□ MississippiCAN	□ Provider Payment	□ Medical Services
□ Beneficiary eligibility	□ Provider Enrollment	□ Fee Schedule
□ Beneficiary Coverage	□ Payment Denials	□ EPSDT
□ Beneficiary Question or Inquiry	□ NCCI Edits	□ Long-Term Care
□ Provider Payment		□ Pharmacy
□ Other_____		

Please explain Question or Complaint.